Behavioural Psychotherapy, 1986, 14, 91–93

Correspondence

To the Editor,

We note with interest Dr. Thomas' remarks on our paper "Cognitive therapy of obsessive-compulsive disorder: treating treatment failures." Any apparent confusion appears to arise from the differing standpoints which Thomas and ourselves have taken. We have started from Foa's (1979) empirical observation that patients who "believed that their fears were realistic, i.e. they manifested overvalued ideation" do not respond to behavioural treatment. We have gone on to attempt, as a secondary concern, to clarify the issues from the standpoint of traditional descriptive psychiatric phenomenology. Thomas, on the other hand, has considered the issue in the first instance from a descriptive phenomenological standpoint without taking the treatment failures literature into account at all. We believe that the primary concern in behaviour therapy should be empirical, and that the phenomenological stance may be useful in helping us arrive at operational definitions which may in turn be of use in carrying out functional analysis, but is of itself notoriously resistant to empirical investigation. Even so, it appears that Thomas has not examined the phenomenology closely enough in this instance.

(i) Taking our primary intention first; the case is clear in this respect. In the original article, we note that the patient had obsessional ideas (regarded as senseless, belief rating of 0·5%); the effect of exposure treatment on subjective ratings closely match those described by Foa (1979) as typical of obsessional patients. Following the "psychotic depression," the ideas were regarded as realistic (belief rating of 98%) and the effects of exposure had changed dramatically. Furthermore, both the altered response to exposure and the changed belief continued after the symptoms of depression had gone. At this point, the patient was therefore displaying the characteristics reported as being typical of patients who do not respond to behavioural treatment (Foa, 1979; Rachman, 1983). As would be expected, exposure treatment was not effective. At this stage, the cognitive intervention was employed, and belief rating fell to 10%. Thus, as we adopted the operational definition of overvalued ideation given by Foa (which is generally accepted by behaviour therapists working with obsessional patients) then no confusion whatsoever arises and our conclusion about the development of overvalued ideation is justified.

(ii) We do consider there to be some limited value in considering overvalued ideation in obsessional patients from a descriptive phenomenological view. Nonetheless, Thomas is still inaccurate in his view that the fears simply became "more prominent," with the implication that the ideas were still characteristic of obsessional thoughts. Phenomenologically, it is demanded that obsessional ideas be regarded by the patient as senseless; this was the case before the "psychotic episode," but not after. There is a suggestion in our paper that the change in the belief may have been brought about by the extreme intensity of fear concerning the possibility of cancer (p. 252). This in turn could have arisen from an abnormal arousal state associated with the psychotic depression. Such a view is entirely consistent with McKenna's (1984) review of disorders with overvalued idea.

Ultimately, however, we would strongly question the utility of rigidly applied descriptive phenomenological psychopathology in contributions to the development of cognitive-behavioural psychotherapy. Such an approach to psychopathology is based primarily on clinicians' subjective appraisal of interview data. On the other hand, we consider that single case experimental studies (of the type reported in our paper) can make a distinctive contribution to psychopathology by generating testable hypotheses and making specific predictions. For instance, since writing this paper, the authors have encountered a further case of overvalued obsessional ideation (sic) in whom the transition from obsessional ideas (regarded as senseless) to ideas firmly believed coincided with a puerperal psychosis. This clearly provides further support for one of the hypotheses generated by our paper. Further testing could be carried out by evaluating the incidence of severe depression at the time of such transitions in a number of similar patients and comparing this to other changes reported in belief or attitude. It has been suggested elsewhere (Salkovskis, 1984) that our understanding of psychopathology is more likely to be enhanced by experimental investigations of single subjects of the type reported in our paper rather than attempts to adhere to rigidly defined descriptive nosology.

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https://doi.org/10.1017/S0141347300012532 Published online by Cambridge University Press

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